STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Arizona Health Care Cost Containment System

Division of Member Services

REPORT HIGHLIGHTS
PERFORMANCE AUDIT

Subject

The Arizona Health Care Cost Containment System (AHCCCS) administers the State's Medicaid program. AHCCCS' Division of Member Services sees that Medicaid determinations are accurate and timely. It also determines eligibility for several other healthcare programs. Finally, it provides information to healthcare providers and AHCCCS members through a 24-hour phone center.

Our Conclusion

AHCCCS contracts with DES to perform most Medicaid eligibility decisions. Shortly after AHCCCS began contracting with DES a number of problems arose, which DES has been working to address. During our audit, AHCCCS also made several positive changes in the way it handles eligibility for other healthcare programs. It has also improved customer service by implementing a variety of automated methods at its 24-hour phone center.

2002

July • Report No. 02 – 05

Changes Address the Increase in Medicaid Applicants

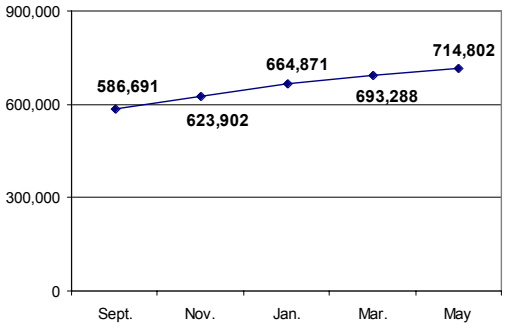
In November 2000, Arizona voters passed Proposition 204, which directed the use of multi-state tobacco settlement money to help provide medical coverage to Arizona citizens whose income falls below the Federal Poverty Level.

Federal Poverty Levels
2002 Calendar Year

- Family of four—$18,100
- Individual—$8,860

Enrollment increased—In the first 9 months after Medicaid eligibility was expanded, enrollment increased by over 100,000.

Medicaid Enrollment
September 2001 through May 2002



.

In addition to expanded eligibility, services are now covered retroactively to the first day of the month in which the member becomes enrolled. Previously, AHCCCS covered only those services rendered in the 48 hours prior to enrollment. This change helped hospitals because about 3 percent of Medicaid applications involve persons who do not apply until after they have already been hospitalized and received services.

Eligibility determination shifted—Along with the other changes, the responsibility for determining eligibility was changed. The counties determined eligibility for many of the State's healthcare programs until Proposition 204 was passed and the Legislature shifted this responsibility to DES.

Hospital concerns—The large increase in enrollment and the change to having DES determine eligibility initially led to a number of concerns on the hospitals' part. Hospitals reported that:

- They were not informed of their patients' eligibility status. Without this information, a hospital would not know whether to bill a health plan or the patient
- Although more persons were now eligible, hospitals were still faced with many "treat and release" patients who were treated without being admitted and then disappeared before applying for Medicaid
- There were delays in entering application data into the state computer system, making it difficult for hospitals to determine if a patient had already applied for Medicaid
- Former county workers hired by DES were unfamiliar with DES procedures, creating errors that slowed the process

DES has taken positive steps to adjust to these challenges by:

- Making eligibility status available earlier to the hospitals
- Making eligibility staff available at some hospitals 24 hours a day to reach as many eligible "treat and release" patients as possible
- Immediately entering "treat and release" applicant information into the DES computer system
- Training former county workers to use the DES computer system
- Exploring ways for hospitals to have limited automated access to member eligibility information

AHCCCS is ultimately responsible for ensuring that eligibility is determined accurately and in a timely manner—AHCCCS has recently begun to monitor the timeliness of DES' eligibility determinations and will begin to monitor DES' accuracy in September 2002.

AHCCCS Has Addressed Eligibility Processes for ALTCS and Other Programs

While AHCCCS contracts with DES to handle the eligibility determinations for the Medicaid program, the AHCCCS Division of Member Services handles eligibility for these programs:

- Arizona Long Term Care System (ALTCS) serves approximately 34,000 elderly and physically or developmentally disabled persons who require a high level of care and are financially and medically eligible
- Supplemental Security Income—Medical Assistance Only (SSI/MAO) for about 18,500 elderly, blind, or disabled persons who may qualify for Medicaid
- KidsCare, a health insurance program for about 48,200 Arizona children 18 and under who are not covered by insurance and who do not qualify for Medicaid

During the course of our audit, AHCCCS significantly reduced its workload for its medical reassessment processes for ALTCS and addressed a backlog in SSI/MAO. However, it can still drop unnecessary procedures used for KidsCare.

AHCCCS has reduced the number of reassessments—AHCCCS used to conduct regular medical reassessments for each ALTCS member. However, AHCCCS analyzed last year's reassessments and found that fewer than 1 percent (150) were no longer medically eligible. In April 2002, the Division reduced the number of reassessments to approximately 1,000 from about 16,500 because data showed that the medical condition of most members would not change, but it has not yet made a corresponding change in its rule requiring the reassessments.

AHCCCS has addressed increases in SSI/MAO workload—After Proposition 204 took effect, the SSI/MAO enrollment increased by more than 450 percent, from about 4,000 in March 2001 to almost 18,500 a year later. The number of new applications led to a 6-month halt in processing renewal applications. AHCCCS increased the number of employees from 23 to 78 during the audit and is again processing renewal applications; however, considering the workload, AHCCCS needs to continue to monitor how well this group is doing.

AHCCCS should discontinue calculating KidsCare error rates—AHCCCS uses a quality control (QC) process to calculate the error rates made by KidsCare eligibility workers. However, this process is invalid because the QC staff:

- Uses a later income period than does the eligibility worker
- Uses different standards than the eligibility worker for documenting income information. Eligibility workers are encouraged to accept the family's declaration of income, but QC workers use pay stubs or other documents

- Review only approved applications and do not review denied applications

Further, AHCCCS is not required by federal or state law to conduct those reviews. Discontinuing these unnecessary reviews would free four staff members who could be used for other duties.

Recommendations

AHCCCS should:

- Change its rule regarding medical assessments to formally discontinue them for most ALTCS members
- Continue to monitor its SSI/MAO workload
- Discontinue calculating error rates for the KidsCare program

Communications Center Services Have Improved

AHCCCS operates a 24-hour Communications Center to provide information to AHCCCS members, healthcare providers, and others. AHCCCS members can call the center for general information and questions about procedures covered under their health plan.

AHCCCS has developed two automated systems that healthcare providers, such as hospitals, doctors, and labs, can use to verify enrollment.

Communications Center Services

67 operators provide 24-hour assistance
- Handle over 100,000 calls per month

Automated systems
- Electronic verification units verified 493,000 members in February 2002
- The touch-tone phone system verified 72,000 members in February 2002

An Internet-based system is currently being developed

Enrollment verification units are communications devices that providers lease from private vendors. Providers pay a subscription fee and a 20- to 35-cent transaction fee. Some units allow providers to transmit multiple verification requests at the same time.

Providers can also verify enrollment by using a touch-tone phone. This service is free but does not allow for multiple verifications.

AHCCCS is also developing an Internet-based enrollment verification system. AHCCCS would offer this service free of charge to providers.

The Center's Incentive Program Needs Some Fine-Tuning

To improve the center staff's performance, operators and their supervisors can earn up to an additional $200 per month in incentive pay if their team meets target goals.

These goals include:

- Attendance
- Answering 90 percent of the calls before the caller hangs up

- The quality of customer service as rated by the team supervisor

However, after reviewing incentive programs used by other call centers, we found the center could improve its measures by:

- Measuring the average time it takes to handle a call rather than the number of unanswered calls
- Having a supervisor from a different team rate the quality of customer service, or rating supervisors using different criteria than their teams'

AHCCCS should also regularly survey AHCCCS members and healthcare providers to assess their needs and satisfaction with the call center's services. AHCCCS has yet to survey members and has not surveyed providers since 1999.

Recommendations

AHCCCS should:

- Use a better measure of individual operator performance such as the average time to handle a call
- Survey providers and members about the quality of service they receive from the Communications Center

TO OBTAIN MORE INFORMATION

A copy of the full report can be obtained by calling
(602) 553-0333

or by visiting
our Web site at:
www.auditorgen.state.az.us

Contact person for
this report:
Lisa Eddy